State of California
Governor's Office of Emergency Services

FORENSIC MEDICAL REPORT: ELDER AND DEPENDENT ADULT ABUSE AND NEGLECT EXAMINATION

OES 602

For more information or assistance in completing the OES 602, please contact
University of California, Davis California Medical Training Center at:
(888) 705-4141 or **www.calmtc.org**

This form is available on the following website:
http://www.oes.ca.gov
Criminal Justice Programs Division
Publications and Brochures

Forensic Medical Report: Elder and Dependent Adult Abuse & Neglect Examination
State of California
Governor's Office of Emergency Services
OES 602 PART 1: INTERVIEW

Confidential Document: Restricted Release | **Patient Identification:** | **Date:**

A. GENERAL INFORMATION ☐ Elder Abuse Exam ☐ Dependent Adult Abuse Exam

1. Patient's Last Name | **First Name** | **M.I.**

2. Street Address	City	County	State	Zip Code	Telephone (Home) (Work)

3. Age	DOB	Gender	Ethnicity		
		☐ Female ☐ Male	☐ White ☐ Black / African American	☐ Hispanic / Latino ☐ Asian ☐ American Indian / Alaskan Native	☐ Native Hawaiian / Other Pacific Islander ☐ Other _____

4. Name and address of facility where exam performed	If patient transferred from another facility, name and address of facility

5. Patient Arrival		Patient Discharged		6. Exam Started		Exam Completed	
Date	Time	Date	Time	Date	Time	Date	Time

7. Interpreter Used ☐ No ☐ Yes Language Used: _____

Name of Interpreter: _____ Telephone: _____

Affiliation of interpreter: ☐ Facility Interpreting Services
☐ Contracted Agency, specify: _____
☐ Family ☐ Friend ☐ Other, specify:

B. MANDATORY REPORTING FOR ELDER AND DEPENDENT ADULT ABUSE

☐ Adult Protective Services ☐ Ombudsman ☐ Law Enforcement ☐ Other: _____ ☐ Telephone Report

Name of Person Taking Telephone Report	Date	Name of Agency	☐ Written Report Submitted
Name of Person Taking Telephone Report	Date	Name of Agency	☐ Written Report Submitted

C. RESPONDING PERSONNEL TO MEDICAL FACILITY ☐ Law Enforcement ☐ APS ☐ Ombudsman

Name	Agency	ID Number	Telephone

D. REQUEST AND AUTHORIZATION FOR MEDICAL EVIDENTIARY EXAM: Follow local policy ☐ Not Applicable

	Name	Agency	ID Number
☐ Law Enforcement Officer ☐ Adult Protective Services ☐ Ombudsman			

E. PATIENT INFORMATION

1. I understand that hospitals and health care professionals are required by Penal Code §11160-11161 to report to law enforcement authorities cases in which medical care is sought when injuries have been inflicted upon any person in violation of any state penal law. The report must state the name of the injured person, current whereabouts, and the type and extent of injuries. ____(initial)
2. I have been informed that victims of crime are eligible to submit crime victim compensation claims to the California Victim Compensation Program (VCP) for out-of-pocket medical expenses, psychological counseling, loss of wages, job retraining and rehabilitation. ____(initial)

F. PATIENT CONSENT

1. I understand that a medical evidentiary examination for evidence of abuse and/or neglect can, with my consent, be conducted by a health care professional to discover and preserve evidence. If conducted, the report of the examination and any evidence obtained will be released to investigative authorities. I understand that the examination may include the collection of reference specimens at the time of the examination or at a later date. I understand that I may withdraw consent at any time for any portion of the examination. ____(initial)
2. I understand that collection of evidence may include photographing injuries and that these photographs may include the genital area. ____(initial)
3. I hereby consent to a medical evidentiary examination for evidence of abuse and/or neglect. ____(initial)
4. I understand that data without patient identity from this report may be collected for health and forensic purposes, and provided to health authorities and other qualified persons with a valid educational or scientific interest for demographic and/or epidemiological studies. ____(initial)

☐ Patient ☐ Surrogate ☐ Conservator ☐ Other: _____

Print Name _____ Signature _____ Date _____

G. DISTRIBUTION OF OES 602 (check all that apply)

☐ Local Law Enforcement - Original ☐ Adult Protective Services - Copy ☐ Crime Lab - Copy ☐ Ombudsman - Copy ☐ Other Agency
☐ Medical Facility Records - Copy ☐ Bureau of Medi-Cal Fraud & Elder Abuse - Copy ☐ District Attorney - Copy Specify: _____

PART I: INTERVIEW
PATIENT HISTORY

H. SUSPECTED TYPES OF ABUSE BEING REPORTED

1. Interview audio and/or video taped ☐ No ☐ Yes

Patient Identification: **Date:**

2. Name(s) of person(s) providing history	**Relationship to patient**	**Telephone**

3. Form(s) of abuse and neglect described

	No	Yes	Unknown	Describe
Physical Abuse				
1. Physical blows and/or ☐ grabbing ☐ holding ☐ pinching ☐ pushing	☐	☐	☐	
2. Strangulation	☐	☐	☐	
3. Bites	☐	☐	☐	
4. Weapons ☐ Firearm ☐ Knife ☐ Blunt object ☐ Other	☐	☐	☐	
5. Burns ☐ Thermal ☐ Chemical	☐	☐	☐	
6. Physical restraints	☐	☐	☐	
7. Chemical restraints	☐	☐	☐	
8. Poisoning	☐	☐	☐	
9. Involuntary alcohol/drug use	☐	☐	☐	
Sexual Assault (Consult with law enforcement)	☐	☐	☐	
Financial				
1. Misappropriation of money	☐	☐	☐	
2. Property transfer	☐	☐	☐	
3. Other: _____	☐	☐	☐	
Abandonment				
1. Desertion	☐	☐	☐	
2. Patient left alone in unsafe circumstances	☐	☐	☐	
Isolation				
1. False imprisonment	☐	☐	☐	
2. Patient prevented from seeing family/social contacts	☐	☐	☐	
3. Patient prevented from receiving mail/phone calls	☐	☐	☐	
4. Patient prevented from keeping appointments with medical, legal, or other service providers	☐	☐	☐	
Abduction	☐	☐	☐	
Neglect				
1. Unsafe environment	☐	☐	☐	
2. Inadequate provision for heat or cooling	☐	☐	☐	
3. Malnutrition	☐	☐	☐	
4. Dehydration	☐	☐	☐	
5. Pressure ulcers	☐	☐	☐	
6. Medication not given as prescribed	☐	☐	☐	
7. Failure to provide patient with glasses, walker, wheel-chair, hearing aide, dentures, or assistive devices	☐	☐	☐	
8. Failure to seek physician services or follow physician orders	☐	☐	☐	
9. Care plan not followed	☐	☐	☐	
Self-Neglect				
1. Failure to live in a safe environment	☐	☐	☐	
2. Inability or failure to perform self-care tasks	☐	☐	☐	
Psychological Abuse				
1. Threats of harm/intimidation If yes, target of threat: ☐ patient ☐ family ☐ pet ☐ other	☐	☐	☐	
2. Harassment	☐	☐	☐	
3. Emotional abuse	☐	☐	☐	
Other:	☐	☐	☐	

I. ALLEGED PERPETRATOR(S)

Name(s)	Age/DOB	Gender	Ethnicity	Address	Telephone	Relationship to patient

J. LOCATION WHERE ABUSE AND NEGLECT OCCURRED

PART I: INTERVIEW
FUNCTIONAL, COGNITIVE, MENTAL HEALTH, AND SUBSTANCE ABUSE SCREENING

Patient Identification: **Date:**

K. FUNCTIONAL HISTORY: Indicate any limitations

	Independent	Needs Assistance	Totally Dependent	Unknown		Independent	Needs Assistance	Totally Dependent	Unknown
Bathing	☐	☐	☐	☐	Medication management	☐	☐	☐	☐
Dressing	☐	☐	☐	☐	Housekeeping	☐	☐	☐	☐
Going to toilet	☐	☐	☐	☐	Laundry	☐	☐	☐	☐
Transferring	☐	☐	☐	☐	Transportation management	☐	☐	☐	☐
Continence	☐	☐	☐	☐	Handling finances	☐	☐	☐	☐
Eating	☐	☐	☐	☐	Vision	☐	☐	☐	☐
Telephoning	☐	☐	☐	☐	Hearing	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	Communication	☐	☐	☐	☐
Preparing meals	☐	☐	☐	☐	Judgement	☐	☐	☐	☐

L. DISABILITY? ☐ No ☐ Yes If yes, ☐ Cognitive ☐ Developmental ☐ Physical ☐ Blind ☐ Deaf/HOH ☐ Mental

M. COGNITIVE ASSESSMENT - MINI-MENTAL STATE EXAM (Score one point for each correct answer)

Max. Points	Patient Score	Orientation
5	( )	What is the (year) (season) (date) (day) (month)?
5	( )	Where are we (state) (county) (town/city) (building) (floor)?
		Registration
3	( )	Ask patient to name three common objects (e.g., "apple," "table," "penny") _____ Take one second to say each. Then ask the patient to repeat all three after you have said them. Give one point for each correct answer. Then repeat them until he/she learns all three. Count trials and record. Trials: ( )
		Attention and Calculation
5	( )	Spell "world" backwards. The score is the number of letters in the correct order. (D__ L__ R__ O__ W__)
		Recall
3	( )	Ask for the three objects repeated above. Give one point for each correct answer. (Note: recall cannot be tested if all three objects were not remembered during registration.)
		Language
2	( )	Name a "pencil" and a "watch."
1	( )	Repeat the following: "no if's, and's, or but's."
3	( )	Follow a three-state command: "Take a paper in your right hand, fold it in half and put it on the floor."
1	( )	Read and obey the following: "Close your eyes"
1	( )	Write a sentence
1	( )	Copy this design
		Scoring **Number of years of education:** _____
30	( )	Total
	( )	Age/education corrected score (see instructions)

N. MENTAL HEALTH AND SUBSTANCE ABUSE SCREENING

Ask the patient:	No	Yes
1. Do you feel your life is empty?	☐	☐
2. Do you often feel sad?	☐	☐
3. Do you feel "pretty worthless" the way you are now?	☐	☐
4. Have you had recent thoughts of suicide?	☐	☐
5. Do you have a history of substance abuse?	☐	☐

O. INTERVIEWER FOR PART I

Signature

Printed Name ID No./License No.

Agency/Facility

Telephone Date

PART II: MEDICAL ASSESSMENT

P. ABUSE AND NEGLECT RELATED MEDICAL HISTORY | **Patient Identification:** | **Date:**

1. Date(s) of abuse and/or neglect | **Time/time frame of abuse and/or neglect**

2. Description of abuse and/or neglect:

3. Past history of abuse? ☐ No ☐ Yes ☐ Unknown When?
Reported? ☐ No ☐ Yes ☐ Unknown Where?

4. Any recent (60 days) surgeries, diagnostic procedures, psychiatric or medical treatment that may affect the interpretation of current physical or cognitive findings? ☐ No ☐ Yes ☐ Unknown If yes, describe

5. Any other pertinent medical condition(s) that may affect the interpretation of current physical findings?
☐ No ☐ Yes Unknown If yes, describe:

6. Any pre-existing physical injuries? ☐ No ☐ Yes ☐ Unknown If yes, describe:

7. Name(s) of current/prior health care providers	**Address**	**Telephone**

8. Current use of medication(s) ☐ **No** ☐ **Yes** ☐ **Unknown**	**Dose/frequency**	**Time of last dose**
Aspirin		
Nonsteroidal anti-inflammatory drugs		
Coumadin		

9. Abuse and/or neglect related cognitive change(s)?

	No	Yes	Unknown	
Loss of memory?	☐	☐	☐	
Change in level of consciousness?	☐	☐	☐	
Recent consumption of alcohol?	☐	☐	☐	
If yes, collection of toxicology samples is recommended according to local policy. ☐ Blood ☐ Urine				
Other	☐	☐	☐	

PART II: MEDICAL ASSESSMENT

Q. GENERAL PHYSICAL EXAMINATION

1. Describe general physical appearance and hygiene.

2. Describe general demeanor/behavior during exam.

Patient Identification: **Date:**

3. Describe condition of clothing. Collect, if indicated. _____

4. Describe condition of glasses, dentures, hearing aides, wheelchairs, canes, walkers, etc. Collect, if indicated.

_____

_____

5. Status of nutrition	No	Yes	Describe
Adequately nourished	☐	☐	
Cachexia	☐	☐	
Temporal wasting	☐	☐	
Status of hydration:			
Adequate hydration	☐	☐	
Dry mucous membranes	☐	☐	
Poor skin turgor	☐	☐	

6. Pain Scale

For verbal patients:
Patient's self-rated pain status:
1 -10_____
Location(s) of pain:
_____
_____
_____

For nonverbal patients:

Observed evidence of pain:

7. Vital Signs

Blood pressure lying _____ Sitting _____ Standing _____ Temperature_____

Pulse lying _____ Sitting _____ Respiration(s) _____ Oxygen Saturation _____

Height _____ Weight _____ Prior weight _____ Date of prior weight _____

8. Conduct a general physical exam and record findings.

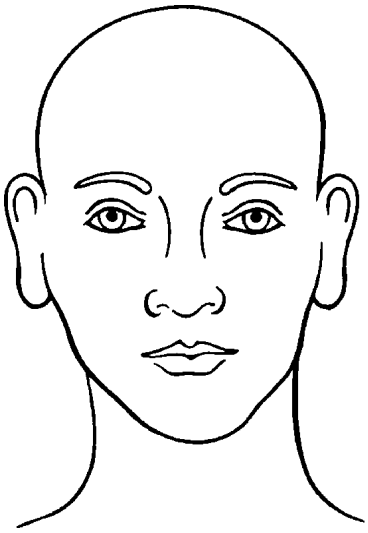
	WNL	ABN	Not Examined	See Diagrams	Describe Abnormal Findings
Skin					
Head					
Eyes					
Ears					
Nose					
Mouth/pharynx					
Teeth					
Neck					
Thorax					
Back					
Breasts					
Cardiac					
Pulmonary					
Abdomen					
Rectal					
Genitalia					
Musculoskeletal					
Neurological					
Including gait					

PART II: MEDICAL ASSESSMENT
R. GENERAL PHYSICAL EXAMINATION

Examine the face, head, hair, scalp, neck and mouth for injury and foreign materials. Measure all findings. Record all findings using photographs, diagrams, legend, and a consecutive numbering system.

Patient Identification: **Date:**

A



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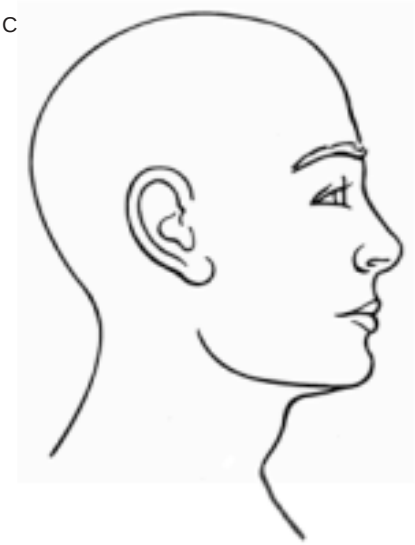

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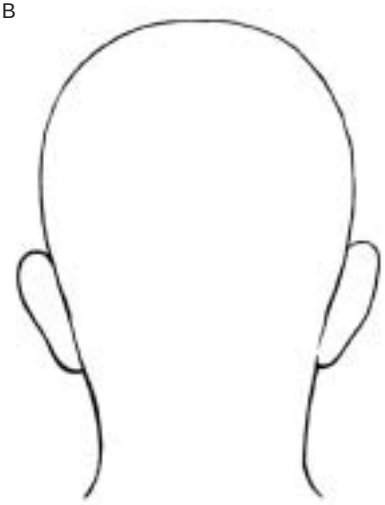

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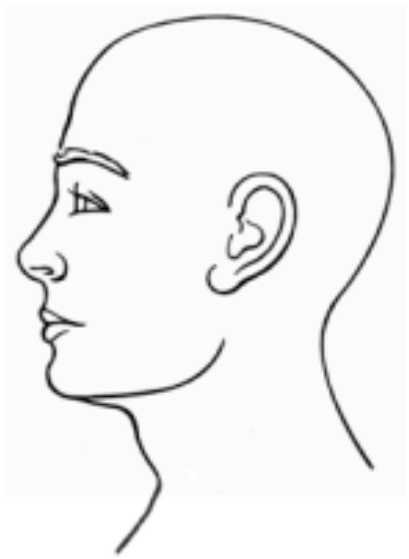

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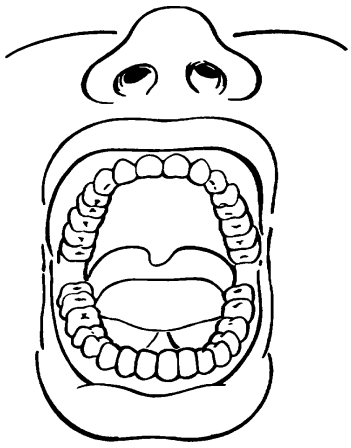


LEGEND: Types of Findings ☐ **Findings** ☐ **No Findings**

AB	Abrasion	**DM**	Dry Mucous Membranes	**F/H**	Fiber/Hair	**LA**	Laceration	**PU**	Pressure Ulcer (indicate State I, II, III, IV)
AL	Alopecia	**DF**	Deformity	**FB**	Foreign Body	**OF**	Other Foreign Materials (describe)	**SC**	Scratch
BI	Bite	**DS**	Dry Secretion	**FR**	Fracture	**OI**	Other Injury (describe)	**ST**	Skin Tears
BU	Burn	**EC**	Ecchymosis (bruise) color	**IN**	Induration	**PE**	Petechiae	**TD**	Tooth Decay
DE	Debris	**ED**	Edema	**INF**	Infestation	**PI**	Pattern Injury	**UI**	Urinary Soiling
DEN	Denture	**ER**	Erythema (redness)	**IW**	Incised Wound				
		FI	Fecal Soiling						

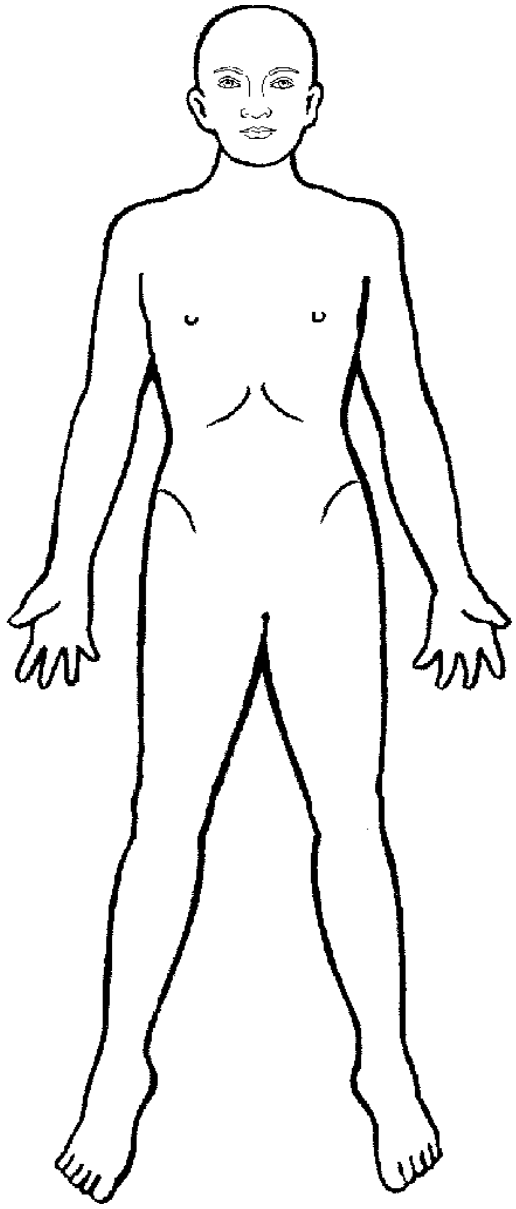
Locator #	Type	Description	Locator #	Type	Description

R. GENERAL PHYSICAL EXAMINATION (cont.)

Conduct physical examination of body and extremities. Record all findings using diagrams, legend and a consecutive numbering system. Measure all applicable findings.

Patient Identification: **Date:**

G



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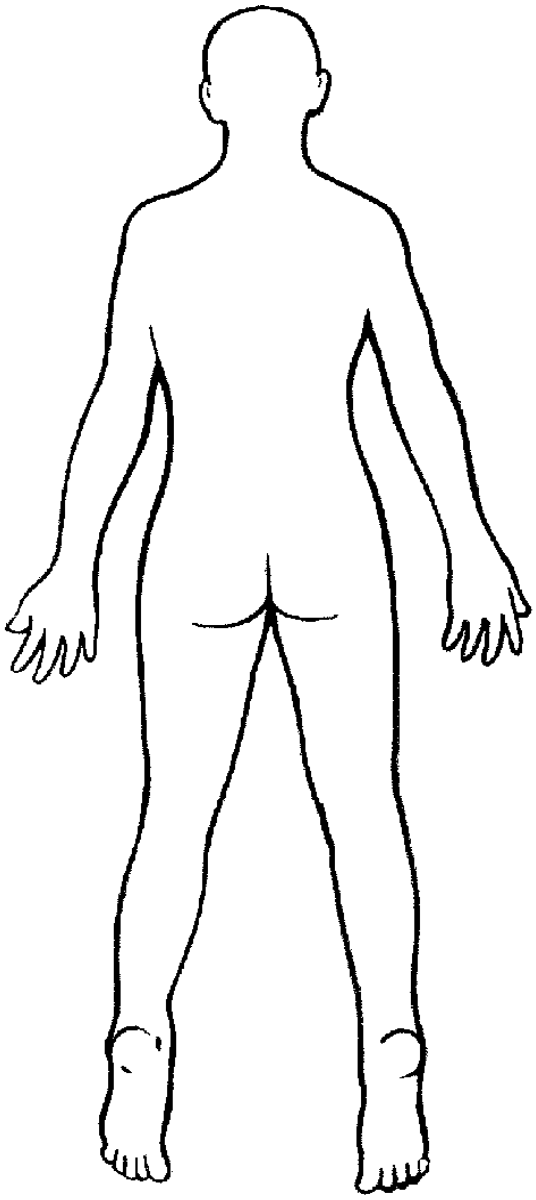


LEGEND: Types of Findings ☐ **Findings** ☐ **No Findings**

AB Abrasion	**DF** Deformity	**F/H** Fiber/Hair	**LA** Laceration	**PU** Pressure Ulcer (indicate State I, II, III, IV)
AL Alopecia	**DS** Dry Secretion	**FB** Foreign Body	**OF** Other Foreign Materials (describe)	
BI Bite	**EC** Ecchymosis (bruise) color	**FR** Fracture		**SC** Scratch
BU Burn	**ED** Edema	**IN** Induration	**OI** Other Injury (describe)	**ST** Skin Tears
DE Debris	**ER** Erythema (redness)	**INF** Infestation	**PE** Petechiae	**UI** Urinary Soiling
DM Dry Mucous Membranes	**FI** Fecal Soiling	**IW** Incised Wound	**PI** Pattern Injury	

Locator #	Type	Description	Locator #	Type	Description

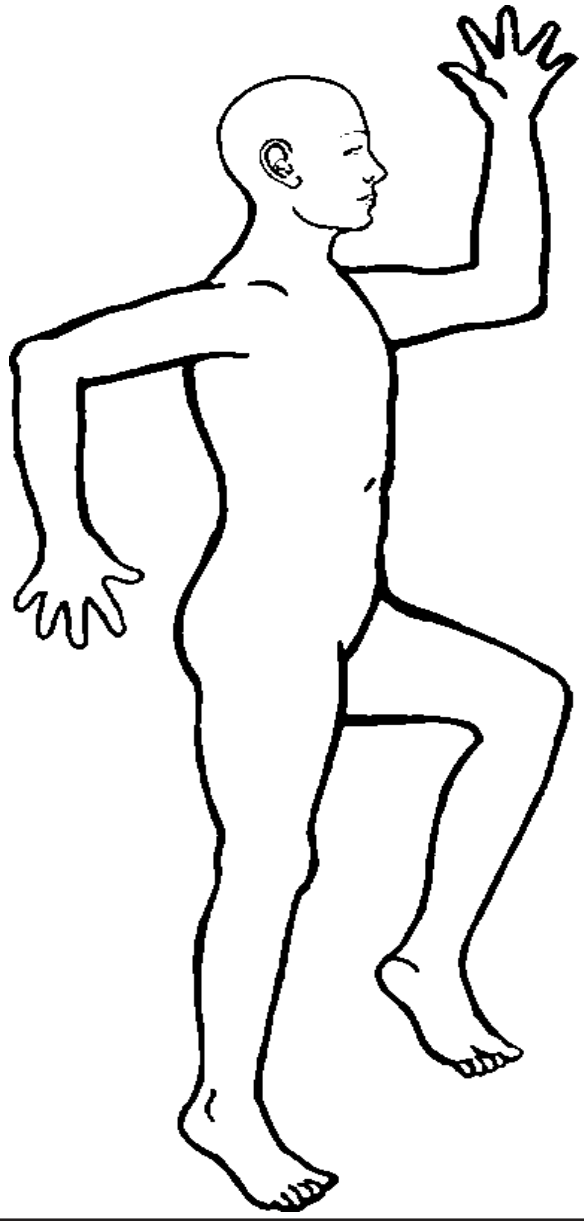
R. GENERAL PHYSICAL EXAMINATION (cont.)

Use diagrams I and J to record findings to lateral or medial aspect of trunk and/or extremities. Record all findings using photographs, diagrams, legend and a consecutive numbering system. Measure all applicable findings.

Note: If genital injuries sustained, use pages 6 and 7 from OES 923 Forensic Medical Report: Acute Adult/Adolescent Sexual Assault Examination form to document findings.

Patient Identification: **Date:**

I



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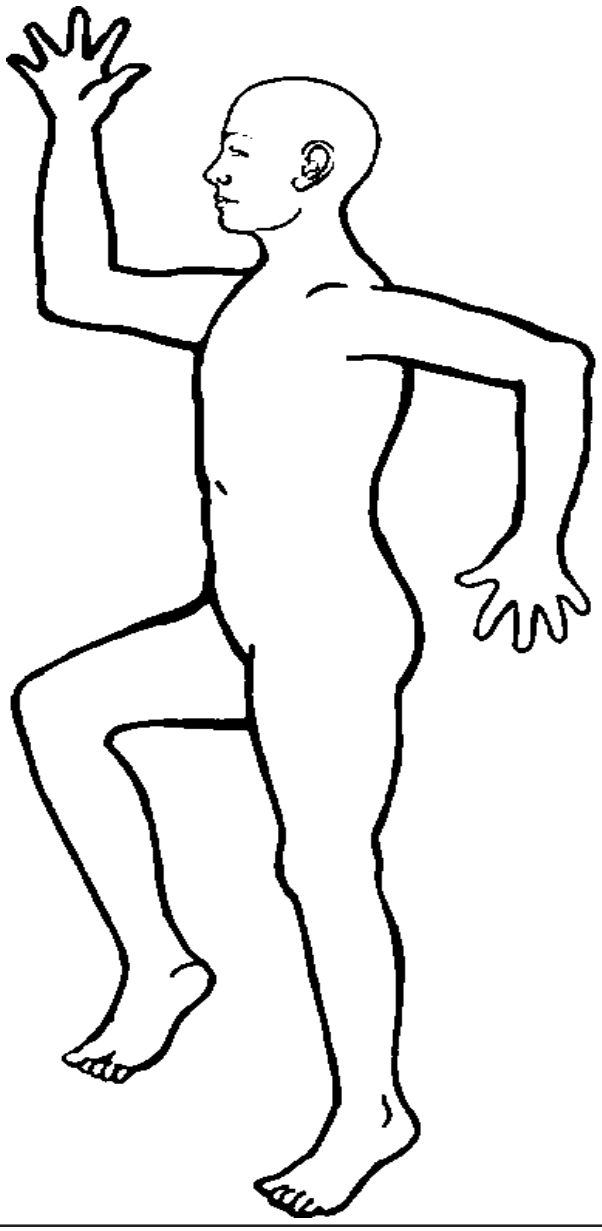

LEGEND: Types of Findings ☐ Findings ☐ No Findings

AB	Abrasion	**DF**	Deformity	**F/H**	Fiber/Hair	**LA**	Laceration	**PU**	Pressure Ulcer (indicate State I, II, III, IV)
AL	Alopecia	**DS**	Dry Secretion	**FB**	Foreign Body	**OF**	Other Foreign Materials (describe)	**SC**	Scratch
BI	Bite	**EC**	Ecchymosis (bruise) color	**FR**	Fracture	**OI**	Other Injury (describe)	**ST**	Skin Tears
BU	Burn	**ED**	Edema	**IN**	Induration	**PE**	Petechiae	**UI**	Urinary Soiling
DE	Debris	**ER**	Erythema (redness)	**INF**	Infestation	**PI**	Pattern Injury		
DM	Dry Mucous Membranes	**FI**	Fecal Soiling	**IW**	Incised Wound				

Locator #	Type	Description	Locator #	Type	Description

PART II: MEDICAL ASSESSMENT
SUMMARY OF FINDINGS

Patient Identification: **Date:**

S. EVIDENCE COLLECTED AND SUBMITTED TO CRIME LAB

1. Clothing Collected	No ☐	Yes ☐	Placed in Evidence Kit	Placed in Paper Bag

2. Foreign Materials	N/A	No	Yes	Collected by:
Swabs/suspected blood	☐	☐	☐	
Dried secretions	☐	☐	☐	
Fibers/loose hairs	☐	☐	☐	
Soil/debris/vegetation	☐	☐	☐	
Swabs/suspected saliva	☐	☐	☐	
Foreign body	☐	☐	☐	
Fingernail scrapings	☐	☐	☐	
Control swabs	☐	☐	☐	
Other (specify)	☐	☐	☐	

T. CLINICALSTUDIES

	No	Yes	Pending	Additional Page
Laboratory Results:	☐	☐	☐	☐ No ☐ Yes
X-ray/Imaging Results:	☐	☐	☐	☐ No ☐ Yes

Toxicology Samples				Time	Collected by
Toxicology screen Results:	☐	☐	☐		
Blood alcohol/toxicology Results:	☐	☐	☐		
Urine toxicology Results:	☐	☐	☐		

Reference Samples

☐ No ☐ Yes ☐ Blood ☐ Saliva

U. PHOTO DOCUMENTATION

☐ No ☐ Yes ☐ 35 mm ☐ Digital ☐ Instant ☐ Other Optics

Photography by: _____ # Rolls/Images _____

☐ Retained ☐ Released to: _____

Recommend follow-up photographs to be taken in 1-2 days ☐ No ☐ Yes ☐ Not applicable

V. DISTRIBUTION OF EVIDENCE	Released to:
Clothing (items not placed in evidence kit)	
Evidence Kit	
Reference Samples	
Toxicology Samples	
Recordings ☐ Audio ☐ Audiovideo	

W. VOICE RECORDING FOR STRANGULATION INJURIES

☐ No ☐ Yes If yes: ☐ Audio ☐ Audiovideo If yes, obtained by: ☐ Examiner ☐ Law Enforcement

X. SUMMARY AND INTERPRETATION OF FINDINGS: _____

If patient expires, contact medical examiner/coroner for an autopsy. ☐ No, not applicable ☐ Yes

Y. FOLLOW UP

Family/friend contact name	Telephone	Follow-up Exam Needed (specify reason):
Location/address of patient following examination	Telephone	

Z. EXAMINER for Part II

Signature of Examiner — Printed name

Signature of Supervising Physician, if applicable

Title — License Number

Medical Facility — Date

Address — Telephone

SIGNATURE OF LAW ENFORCEMENT OFFICER

I have received the evidence indicated above

Signature of Officer — Printed Name

ID Number

Agency:

Telephone

Date: